10/17/2011 PRINTED: FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPI	
		155232	A. BUII B. WIN			- 09/27/2011	
		II .	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	R		1	ST NORTH H ST		
TWIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	REGULATORY OR	LSC IDENTIFFING INFORMATION)	-	IAG	DELICIENCE 17		DATE
F0000							
	This visit was for	r a Post Survey Revisit	F0	000	Submission ofi tthis Plan ofi corre	ctton	
	[PSR] to the Rec	ertification and State			does nott consttttutte an admission		
	Licensure Survey completed on 8/12/11.				or an agreementt witth fiactts alle on tthe survey reportt	eged	
	Survey dates: September 26, 27, 2011				Submission ofi tthis Plan ofi Corre	ctton	
- "· · · · · · · · · · · · · · · · · · ·				does nott consttttutte an admission			
	Facility number:				an agreementt by tthe provider o ttrutth ofi fiactts alleged or correc		
Provider number: 155232				sett fiortth on tthe sttattementt o			
	AIM: 100266140				deficiencies.	•	
	Survey team:				The Plan ofi Correctton is prepare	d	
	Ginger McName	ee, RN, TC			and submitted because ofi	~	
	Delinda Easterly	, RN	requirementts under Sttatte and				
	Betty Retherford	l, RN [9/26/11]			Federal law.		
	Karen Lewis, RN	-					
		_			Please acceptt tthis Plan ofi Corre	ctton	
	Census bed type:				as our credible allegatton ofi compliance.		
	SNF: 9				compliance.		
	SNF/NF: 49						
	TOTAL: 58						
	Census payor typ	oe:					
	Medicare: 9						
	Medicaid: 49						
	Total: 58						
	Sample: 10						
	These deficiencie	es also reflect state					
	findings cited in	accordance with 410 IAC					
16.2.							
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I4K712

Facility ID:

000137

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN NAME OF I	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIES TY HEALTH CARE		LDING STREET A 627 EA	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933	(X3) DATE COMPI 09/27/2	LETED
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE
	Quality review of Cathy Emswiller	completed 9/29/11 r RN				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I4K712

Facility ID: 000137

If continuation sheet

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
III.D I DIIII		155232	A. BUILDING		09/27/2011
			B. WING	CT ADDRESS CITY STATE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
TW/N CI	ΓΥ HEALTH CARE			EAST NORTH H ST CITY, IN46933	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE	DATE
F0157	,	nediately inform the vith the resident's physician;			
SS=D		y the resident's legal			
		an interested family member			
		ccident involving the			
		ults in injury and has the			
		ing physician intervention; a			
	•	in the resident's physical,			
	deterioration in he	social status (i.e., a alth_mental_or			
		is in either life threatening			
		al complications); a need to			
	_	nificantly (i.e., a need to			
		sting form of treatment due			
		uences, or to commence a			
		nent); or a decision to ge the resident from the			
	facility as specified	_			
	lacinty ac opcomo	2 III 3 1001 12(a).			
	The facility must a	lso promptly notify the			
		own, the resident's legal			
		nterested family member			
		ange in room or roommate			
		ecified in §483.15(e)(2); or ent rights under Federal or			
		ations as specified in			
	paragraph (b)(1)	•			
	,				
	•	ecord and periodically			
	-	s and phone number of the			
		presentative or interested			
	family member.		F0157	F 157 I. A. The involved no	urse 10/11/2011
			1.012/	who failed to report to the	10/11/2011
				physician the results of the	
				urinalysis for Resident #45 i	na
				timely manner has been	
				addressed and re-educated.	l l
				Please note that Resident #- has received necessary trea	
				in response to the urinalysis	
				result. B. Please note that	
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: 4	L K712 Facil	lity ID: 000137 If continuation s	sheet Page 3 of 35

Event ID: **|4K712**

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PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) M A. BUII B. WIN		00	(X3) DATE S COMPL 09/27/2	ETED	
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 627 EAST NORTH H ST GAS CITY, IN46933					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
					physician of Resident #45 has been notified and clarification orders received in regard to frequency of accuchecks as as physician call parameter II. In an effort to identify any other resident affected by a potential delay in physician notification, lab results for lad drawn and/or urinalysis ordeduring the prior 30 days as as auditing of the accucheck orders and compliance therefor all applicable residents to be conducted. Should conce be noted, corrective action be taken as warranted. As a residents could potentially be affected, the following correactions shall be taken: III. A means to ensure ongoing compliance with reporting to physician in a timely manner results of lab results (e.g., urinalysis) warranting potenti intervention, as well as blood sugars which fall outside parameters set by the physician for resident with a urinary tract infection to physician in a timely manner reporting to a physician blood sugars above the parameters by the physician per the facil policies and procedures. It we be acceptable to place lab rewhich could indicate treatme warranted in the folder of the physician and/or nurse	well s. bs red with will rns shall ll sctive as the al listan, es on the and discontinuous so the analysis of the analysis so the and discontinuous so the analysis so the anal		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I4K712

Facility ID: 000137

If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CC A. BUILDING	00	(X3) DATE SURVEY COMPLETED 09/27/2011
	PROVIDER OR SUPPLIER		627 EA	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST ITY, IN46933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) practitioner to be reviewed his/her next visit. IV. As a of quality assurance, follow aforementioned in-service training, auditing for compl	on mean ving the
	A. Based on reco	ord review and interview,		shall be completed on schedays of work by designated administrative/nursing staff Designated at the educated as to the expectathorough monitoring for compliance, not only compof the task. Should noncompliance be noted, corrective action including re-education and disciplina action, if warranted, shall be initiated. The assigned nur consultant/ designee shall responsible to visit the faci an, at least, weekly basis to confirm compliance with the reporting of results to the physician in a timely manner (both of labs and of bloods which fall outside of pre-determined parameters. Results of the aforemention audits and immediate corrections taken shall be reported the quality assurance common a quarterly basis for revand potential revision of monitoring, if warranted. Completion Date: 10/11/1	eduled d f f f tion of letion ry e er se be lity on o e er sugars s) ned ective rted to mittee iew
	the facility failed results of a urina for 1 of 1 residen	to report to the physician lysis in a timely manner at reviewed [Resident ary tract infection in a			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155232	A. BUI	LDING	00	09/27/20	
		100202	B. WIN			09/21/20	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
		TATEMENT OF DEFICIENCIES			11,1110000	ı	(27.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	sample of 10. [R						
	B. Based on reco	ord review and interview,					
		to report to the physician					
	l *	ve the parameters set by					
	I -	1 of 5 residents reviewed					
		nonitoring in a sample of					
	10. [Resident #4	-					
	Ľ	j					
	Findings include:						
	A. Resident #45	's clinical record was					
	reviewed on 9/26	5/11 at 9:50 a.m. The					
	resident's diagnos	ses included, but were					
	not limited to, dia						
	depression, and a						
	-	•					
	The resident had	a physician telephone					
	order dated 8/30/	11, to obtain a urinalysis					
	and culture with	sensitivity. The resident					
	had a 9/7/11, ord	er from the Nurse					
	Practitioner for C	Cipro [an antibiotic] 500					
	mg two times a d	lay for seven days.					
		-					
	Review of nurse	progress notes indicated					
	the following:						
	8/30/11, 2:00 p.n	n., Nurse Practitioner					
	[NP] notified. Re	esident presents with					
	confusion and ha	llucinations. Resident					
	stated this a.m. to	"wake me up at 9:00					
		I can go to work at					
		ny]." The resident stated					
		f hospital] in the mental					
		lent stated "Sparks are					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL COMPL					
THEFTER	or condition	155232		LDING		09/27/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R			ST NORTH H ST		
	TY HEALTH CARE			l .	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
1710		wall" and indicated		1710	·		DATE
	snakes were chasing him. The Nurse Practitioner ordered a urinalysis with a						
		tivity to rule out a urinary					
	tract infection [U						
	-	n., Laboratory called for a					
	_	he final result of the					
	1 *	to the facility per request					
	1 *	surse as she was unable to					
	call.						
	9/6/11, 11:57 p.n	n., Results of urinalysis					
	received and not	ed. Information to be					
	given to the day	shift nurse and the Nurse					
	Practitioner.						
	9/7/11, 10:00 a.n	n., Resident seen by					
	Nurse Practition	er and an antibiotic was					
	ordered.						
	Review of a cult	ure and sensitivity report					
	faxed to the facil	lity from the laboratory on					
	9/4/11 at 10:10 a	.m., indicated the urine					
	had Klebsiella P	neumoniae growth count					
	of 60 - 70,000 C	FU/ml [colony forming					
	units per millilite	er.]					
	During an interv	iew with the Director of					
	1	/11 at 4:15 p.m., she					
		/11 faxed report of the					
		aced in the Nurse					
		der for her to review on					
	her next visit.						
	B. Resident #45	's clinical record was					
		6/11 at 9:50 a.m. The					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	OF CORRECTION	155232		LDING	00	09/27/2	
		100202	B. WIN		DDDEGG CIEW CELTE ZID CODE	00/21/2	011
NAME OF I	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
TWIN CI	TY HEALTH CARE				TY, IN46933		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	.	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ses included, but were					
	not limited to, diabetes mellitus,						
	depression, and anxiety.						
		irrent Physician's Orders					
	1	gh 9/30/11 were signed,					
	1	the Physician. The					
		the resident was to have					
	_	od sugar monitoring]					
	_	imes a day and as needed.					
	The orders indicated the physician was to						
		ood sugars greater than					
	250.						
	Review of the "F	Blood Glucose					
		ord" for September, 2011,					
	1	sugars were only checked					
		at 6:30 a.m. and 4:30 p.m.					
	1	d of four times a day as					
	1	hysician. The record					
	1 .	lowing blood sugar					
		m., without the physician					
	being notified.	, without the physician					
	256 on 9/3/11						
	280 on 9/5/11						
	284 on 9/6/11						
	277 on 9/9/11						
	310 on 9/10/11						
	274 on 9/11/11						
	274 on 9/12/11						
	277 on 9/14/11						
		the physician not being					
	_	nes for blood sugars					
	greater than 250	in September, 2011.					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETER					
111,212,111	or conditions	155232				09/27/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			1	ST NORTH H ST		
TWIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		of any indication of the		1710	·		DATE
		notified of the blood					
	1 ^ '	g done two times a day,					
	instead of the fou						
		,					
		eptember, 2011, nurses					
	^ ~	cked an indication of the					
		notified of the blood					
	sugars above 250).					
	Review of the da	ily blood sugar audits,					
		Administrator on 9/26/11					
	^	dicated Resident #45's					
	· ·	re audited on 9/7/11 and					
	_	problems identified.					
	•						
	During an intervi	iew with the Nurse					
	Consultant on 9/2	27/11 at 10:10 a.m., she					
	indicated the phy	sician had not been					
		ood sugars greater than					
	250.						
	The current 1/06	, "Physician & Family					
	l .	cedure" was provided by					
		Fursing on 9/26/11 at 3:40					
		ure indicated the purpose					
		physician apprised of all					
		es. The procedure					
	indicated the phy	sician was to be notified					
	of any changes in	n condition that may or					
	may not warrant	a change in the treatment					
		dure indicated thorough					
	_	rmation reported to the					
	physician with th	e date and time reported					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMP			(X3) DATE COMPL		
		155232	B. WING			09/27/2	011
	PROVIDER OR SUPPLIER		•	627 EAS	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	should be include along with the rephysician.	ed in the nurses notes sponse from the					
	The facility faile	was cited on 8/12/11. d to implement a correction to prevent					
	3.1-5(a)(2) 3.1-5(a)(3)						
F0282 SS=D	facility must be pro- in accordance with plan of care. Based on record facility failed to correctly transcri- medications for 1	the hospital in a sample	f F0282		F 282 I. The physician of Resident #4 has been contact and clarification orders obtain to ensure that Resident #4 is receiving all medications as prescribed by the attending physician. II. In an effort to identify any other residents with might be affected, those residents.	ned ; vho	10/11/2011
	Findings include: The clinical record for Resident #4 was reviewed on 9/26/11 at 12:45 p.m. Diagnoses for Resident #4 included, but were not limited to, hypertension and status post left hip replacement. The clinical record indicated the resident was readmitted to the facility at 10:00				who have been re-admitted to the facility within the last 30 days have been identified and re-admission orders reviewed to ensure correct transcription. III. As a means to ensure going compliance with correctly transcribing and administering medications for residents re-admitted to the facility, the following actions shall be taken: Licensed nursing staff shall receive directed in-service		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155232 09/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 627 EAST NORTH H ST TWIN CITY HEALTH CARE GAS CITY, IN46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE training addressing the correct p.m., on 8/30/11, following transcription and administration of hospitalization for a left hip fracture. The medications following the resident nurse on duty transcribed the transfer having being re-admitted from the readmission medication orders onto the hospital shall be provided. Following said training, the facility "Admission Orders and Plan of Care" will mandate that two licensed record and then onto the August 2011 nurses review re-admission "Medication Administration Record" orders and affirm correct (MAR). The nurse transcribed four transcription of said orders. IV. additional medication orders onto the As a means of quality assurance. the Director of Nursing/designee admission order form and the MAR which shall be responsible to review the had not been reordered following the orders of any newly re-admitted hospital admission. The following four resident on his/her first day of medications were: work following resident re-admission. Should a concern be noted with the transcription of Rulox (an anti-acid medication) re-admission orders, the involved Suspension 30 ml (milliliters) daily. nurse(s) shall be re-educated and disciplinary action taken, if Tramadol (a pain medication) 50 mg warranted. Further, the assigned (milligrams) daily at bedtime. nurse consultant/designee shall Ex-lax (a laxative) 1 tablet at bedtime. be responsible to visit the facility Propranolol (an on an, at least, weekly basis and anti-hypertensive/anti-anginal medication) review the orders of a resident newly admitted to confirm 40 mgs twice daily. continued compliance with the above plan of correction. Results The August 2011 MAR indicated the of the aforementioned audits and following: immediate corrective actions taken shall be reported to the quality assurance committee on a The Rulox was given at 8:00 a.m. on quarterly basis for review and 8/31/11. recommended revision of The Ex-lax and Tramadol were given at monitoring, if warranted. Completion Date: 10/11/11 8:00 p.m. on 8/31/11. The Propranolol medication was given at 8:00 a.m. and 8:00 p.m. on 8/31/11. These medications had been marked out

l '		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155232	A. BUILDING	00	09/27/2011
		133232	B. WING		09/2//2011
NAME OF P	PROVIDER OR SUPPLIER		l l	FADDRESS, CITY, STATE, ZIP CODE AST NORTH H ST	
TWIN CI	TY HEALTH CARE			CITY, IN46933	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	on the September	r 2011 MAR and "not an			
	order" was writte	en by the name of the			
	medication.				
	During an intervi	iew on 9/26/11 at 2:25			
	p.m., the Assistar	nt Director of Nursing			
	-	se on duty had put the			
	four orders noted	l above on the admission			
	order form in err	or. She indicated the			
	resident had prev	viously been on these			
	medications, but	they had not been			
	reordered on 8/30	0/11 and should not have			
	been included on	the re-admission order			
	form. She indica	nted these four			
	medications were	e given in error on			
	8/31/11.				
	This federal tag v	was cited on 8/12/11.			
	The facility failed	d to implement a			
	systemic plan of	correction to prevent			
	recurrence.				
	3.1-35(g)(2)				
F0309	Each resident mus	st receive and the facility			
SS=D	must provide the r	necessary care and services			
		in the highest practicable			
		and psychosocial well-being, n the comprehensive			
	assessment and p				
		review and interview, the	F0309	F 309 I. (1) Please note that	10/11/2011
	facility failed to	ensure blood sugar		physician of Resident #45 ha	
	•	_		been notified and clarificatio	n

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DING	00	COMPLETED	
		155232	A. BUII B. WIN			09/27/20	11
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
				1	ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	monitoring and/or sliding scale insulin				orders received in regard to		
	coverage was pro	ovided as ordered by the			frequency of accuchecks as	well	
		f 5 residents reviewed in			as blood sugar call	.	
	1 ^ *				parameters. (2) The physi		
	a sample of 10.	[Resident #'s 45, 13, 12]			of Resident #13 was address		
					regard to omitted blood suga	irs as	
	Findings include	:			well as incorrect coverage administered. Involved nurse	.	
					were re-educated. (3) The		
	1. Resident #45'	s clinical record was			physician of Resident #12 wa		
		6/11 at 9:50 a.m. The			addressed in regard to incom		
					coverage administered. Inv		
		ses included, but were			nurses were re-educated. II.		
	not limited to, di	· ·			an effort to identify any other	.	
	depression, and a	anxiety.			resident affected by blood su	igars	
					not conducted at the ordere	ed	
	The resident's cu	rrent Physician's Orders			frequency and/or receiving		
		h 9/30/11 were signed,			inaccurate coverage, all		
		the Physician. The			applicable diabetic resident	s	
	1	•			were identified and blood		
		the resident was to have			sugars/coverage performed within the last 30 days will		
	accuchecks [bloc	od sugar monitoring]			conducted. Should concerns	s ha	
	completed four ti	imes a day and as needed.			noted, corrective action shall		
					taken as warranted. As all		
	Review of the "E	Blood Glucose			residents could potentially be		
		ord" for September, 2011,			affected, the following correct		
	_	-			actions shall be taken: III.		
		sugars were only checked			means to ensure ongoing		
		at 6:30 a.m. and 4:30 p.m.			compliance with ensuring blo		
		of four times a day as			sugar monitoring and/or slidi		
	ordered by the pl	nysician. This resulted in			scale coverage is provided a		
	the resident not r	eceiving blood sugar			ordered by the physician, dir	ected	
	monitoring as or				in-service training will be conducted. Said training will	.	
	September, 2011				specifically address the	'	
	September, 2011	•			aforementioned concerns.	v.	
					As a mean of quality assurar		
		ily blood sugar audits,			following aforementioned	,	
	provided by the A	Administrator on 9/26/11			in-service training, auditing for	or	
	at 10:00 a.m., inc	dicated Resident #45's			compliance shall be complet		
	blood sugar's we	re audited on 9/7/11 and			on scheduled days of work b	y	

000137

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232		LDING	NSTRUCTION 00	(X3) DATE COMPI 09/27/2	LETED
	PROVIDER OR SUPPLIER		•	627 EA	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAG	9/22/11 with no puring an interval Nursing on 9/26/20 indicated she thousagar order had be checked two times. 2. The clinical rewas reviewed on Resident #13's cubut were not lime mellitus and more Resident #13 had 8/10/11 which in problem listed as	problems identified. iew with the Director of (11 at 4:15 p.m., she hught the resident's blood been changed to being es a day. ecord for Resident #13 9/26/11 at 11:00 a.m. current diagnoses included, ited to, type 2 diabetes bid obesity If a healthcare plan, dated dicated the resident had a s, the resident has a betes mellitus and is at			designated administrative/n staff. Designated staff shall addressed in regard to thoromonitoring for compliance withe orders; not just completing the task. Should noncompliable noted, corrective action including re-education and disciplinary action, if warran shall be implemented. The assigned nurse consultant/designee shall be responsible visit the facility on an, at lea weekly basis to confirm compliance with adherence conducting blood sugars an provision of sliding scale coverage as per physician's orders. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committed quarterly basis for review are recommended revision of monitoring, if warranted. Completion Date: 10/11/11	be bugh with on of ance ted, lle to st, to d	DAIL

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155232	B. WING		09/27/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
TWIN CI	TY HEALTH CARE		I	AST NORTH H ST ITY, IN46933	
				11 1, 11140933	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
1110		Interventions for this	i i i i		BINE
		d, monitor blood sugars			
	•	dminister sliding scale			
	insulin as ordered.				
	msami as oracie	u.			
	Resident #13 had	l current physician's			
	Resident #13 had current physician's orders for the following,				
	orders for the for	iowing,			
	A Monitor blood	d sugar levels 4 times			
	daily.				
	dany.				
	B. Administer Novolog insulin 40 units subcutaneously three times daily.				
	,				
	C. Administer Le	evemir insulin 72 units			
		every morning and			
	evening.	,			
	D. Administer N	ovolog insulin according			
	to blood sugar re	sults using sliding scale			
	below				
	151 - 200 = 6 un	its			
	201- 250 = 10 ur	nits			
	251 - 300 = 14 u	nits			
	301 - 350 = 20 u	nits			
	315 - 400 = 24 u	nits			
	greater than 400	= 28 units			
			1		

000137

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155232	B. WIN			09/27/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DROWINED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPRO		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The original date	e of all the above orders					
	was 2/3/11.						
	, , , , , , , , , , , , , , , , , , ,						
	Review of the So	eptember 2011 "Blood					
	Glucose Monitoring Record" for Resident						
		the following dates and					
		at did not have blood					
	_	nitored and or receive					
	sliding scale insulin coverage as ordered						
	by the physician,						
	A. 9/1/11 at 4:30 p.m., the blood sugar						
	result was 190.	The resident did not					
	receive any insu	lin coverage. The					
	resident should h	nave received 6 units.					
	B. 9/1/11 at 9:00	p.m., the blood sugar					
		sident did not receive any					
		. The resident should					
	have received 6						
	nave received o	units.					
	C 0/10/11 of 4.2	0 p.m., no blood sugar					
		-					
		nented as having been					
	completed.						
	D 0/24/11 + 4.3	0					
		0 p.m., no blood sugar					
		nented as having been					
	completed.						
	_	iew with LPN #1 on					
		a.m. she indicated the					
	nursing staff wer	re to document blood					
	sugar results and	l sliding scale insulin on					
	1 -	ose Monitoring Record."					
		<u>U</u>					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE S COMPL	
		155232	A. BUII B. WIN			09/27/2	011
	PROVIDER OR SUPPLIER TY HEALTH CARE			STREET A	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	place in the resid where blood sugar scale insulin were 3. The clinical rewas reviewed on Diagnoses for Rewere not limited diabetic neuropate Current physician signed 8/10/11, illimited to, Novol milliliter (ml) to for the following 100 - 150 give 3 151 - 200 give 6 201 - 250 give 10 251 - 300 give 15 greater than 300 Review of the Se Medication Adm (MAR) indicated and times Reside sugar monitored the incorrect slid.	n orders for Resident #12, included, but were not og insulin 100 units per be given subcutaneously blood sugar ranges: units units 0 units give 20 units. ptember, 2011, inistration Record on the following dates nt #12 had her blood as ordered and received ing scale insulin dose: the blood sugar result as 130, no sliding scale in. The resident should					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155232	B. WIN			09/27/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ST NORTH H ST		
TWIN CI	TY HEALTH CARE				TY, IN46933		
					111, 114-40000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	9/3/11 the blood	sugar was 120 at 8 a.m.,					
	no sliding scale i	nsulin was given. The					
	resident should h	have received 3 units.					
	9/3/11 the blood	sugar was 144 at 4 p.m.,					
		-					
	no sliding scale insulin was given. The resident should have received 3 units.						
		sugar was 108 at 4 p.m.,					
	no sliding scale insulin was given. The resident should have received 3 units. 9/6/11 the blood sugar was 107 at 8 a.m.,						
		nsulin was given. The					
		have received 3 units.					
	resident should h	ave received 5 diffes.					
	0/7/11 the blood	sugar was 124 at 8 a.m.,					
		_					
		nsulin was given. The					
	resident should h	have received 3 units.					
	0/5/11						
		sugar was 121 at 4 p.m.,					
		nsulin was given. The					
	resident should h	have received 3 units.					
	9/8/11 the blood	sugar was 130 at 4 p.m.,					
		nsulin was given. The					
		have received 3 units.					
	1001doni bilodid il	are received 5 units.					
	0/21/11 the blee	d sugar was 111 at 8 a.m.,					
		•					
	I -	nsulin was given. The					
	resident should h	have received 3 units.					
	During an interv	iew with the DoN on					
	9/26/11 at 2:45 p	.m., she indicated all					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155232	A. BUILDING B. WING		09/27/2011
	PROVIDER OR SUPPLIER		627 EAS	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	scale coverage had provided audit resinformation relation been completed to this federal tag with the facility failed	ed to auditing having for Resident #12. was cited on 8/12/11.			
F0315 SS=D	assessment, the faresident who enter indwelling cathete the resident's clinicathat catheterization resident who is incappropriate treatments.	dent's comprehensive acility must ensure that a rs the facility without an r is not catheterized unless cal condition demonstrates n was necessary; and a continent of bladder receives tent and services to prevent tions and to restore as much nection as possible.	F0315	F 315 I. The involved nurse failed to report to the physicithe results of the urinalysis for Resident #45 in a timely mar was addressed. Please note Resident #45 has received	an lor lor

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2011
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
				necessary treatment in respect to the urinalysis result. II. I effort to identify any other reaffected by delay in physicial notification, lab results for prior 30 days will be conducted. Should concerns be noted, corrective action shall be tal warranted. As all residents potentially be affected, the following corrective actions be taken: III. As a means the ensure ongoing compliance reporting to the physician in timely manner results of lab results (e.g., urinalysis) warranting potential interver directed in-service training with a urinary tract infection physician in a timely manner prohibition of placing a result warranting potential treatment the folder of the physician/in practitioner for review at the of his/her next facility visit. As a mean of quality assurated following aforementioned in-service training, auditing compliance shall be comple on scheduled days of work designated administrative/in staff. Should noncompliance on the properties of the physician in the comple on scheduled days of work designated administrative/in staff. Should noncompliance on the properties action inclusion, if warranted, shall be implemented. The assigner nurse consultant/ designee be responsible to visit the factor and all east, weekly basis	n an esident an r the eted. ken as could shall on with a mile et to the er and lit ent in urse et time. IV. ance, for eted by ursing se be uding by ete d shall acility.

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155232	A. BUII		00	09/27/2	
		100202	B. WIN		DDDEGG CITY CTATE ZIR CODE	03/21/2	011
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	confirm compliance with the		DATE
					reporting of results to the		
					physician in a timely manner		
					Results of the aforementione		
					audits and immediate correct actions taken shall be reported.		
					the quality assurance commi		
					on a quarterly basis for revie		
					and recommended revision of	of	
					monitoring, if warranted. Completion Date: 10/11/11		
	Based on record	review and interview, the			Completion Date. 10/11/11		
	facility failed to obtain and report results						
	of a urine specimen in a timely manner for						
	1 of 1 residents reviewed with a urinary						
	tract infection in	•					
	[Resident #45]	a sumple of 10.					
	[Resident #43]						
	Findings include	:					
	1. Resident #45'	's clinical record was					
	reviewed on 9/20	6/11 at 9:50 a.m. The					
	resident's diagno	ses included, but were					
	not limited to, di	abetes mellitus,					
	depression, and a	anxiety.					
		a physician telephone					
		/11, to obtain a urinalysis					
	and culture with	sensitivity. The resident					
	had a 9/7/11, ord	ler from the Nurse					
	Practitioner for (Cipro [an antibiotic] 500					
	mg two times a c	day for seven days.					
		,					
		progress notes indicated					
	the following:	TTI : 1 .					
	8/30/11, 1:00 a.n	n., The resident was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **|4K712**

Facility ID:

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If continuation sheet

Page 21 of 35

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	A. BUII	LDING	NSTRUCTION 00	(X3) DATE: COMPL 09/27/2	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	1 55.2.72	
TWIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	[NP] notified. Reconfusion and has tated this a.m. to a.m. tomorrow so [name of compar" I am at [name of ward." The reside coming from the snakes were chast Practitioner order culture and sensitivate infection [U 8/31/11, 5:30 a.m. urinalysis this shabe passed on to desample. 9/1/11, 2:15 p.m. laboratory to pict 9/2/11. 9/6/11, 11:45 p.m. request to have the urinalysis faxed to of the day shift in call. 9/6/11, 11:57 p.m. received and note given to the day shift in call. 9/6/11, 10:00 a.m.	ury from fall. a., Nurse Practitioner esident presents with llucinations. Resident b "wake me up at 9:00 b I can go to work at ay.]" The resident stated f hospital] in the mental eent stated "Sparks are wall" and indicated ing him. The Nurse red a urinalysis with a tivity to rule out a urinary					

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		627 EA	ADDRESS, CITY, STATE, ZIP C ST NORTH H ST ITY, IN46933	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	faxed to the facil 9/4/11 at 10:10 a had Klebsiella Prof 60 - 70,000 Clunits per millilite. During an interv. Nursing on 9/26/indicated the 9/4 urinalysis was pl. Practitioner's fold her next visit. The current 1/06 Notification Proc the Director of Np.m. The proced was to keep the prodiction change indicated the phy of any changes in may not warrant plan. This federal tag of The facility faile	iew with the Director of 211 at 4:15 p.m., she 211 faxed report of the aced in the Nurse der for her to review on 3, "Physician & Family Evedure" was provided by Eursing on 9/26/11 at 3:40 dure indicated the purpose obysician apprised of all es. The procedure visician was to be notified in condition that may or a change in the treatment was cited on 8/12/11.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232			(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2011
	PROVIDER OR SUPPLIER		STREE 627 E	T ADDRESS, CITY, STATE, ZIP CODE EAST NORTH H ST CITY, IN46933	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	from unnecessary drug is any drug w (including duplicat duration; or without without adequate is the presence of accindicate the dose of discontinued; or all reasons above. Based on a compropersident, the facility residents who have drugs are not give antipsychotic drugs treat a specific cordocumented in the residents who use gradual dose reduinterventions, unlein an effort to discontinued; the fact and the residents who use gradual dose reduinterventions, unlein an effort to discontinued; the fact and the signed out and dobeen administered reviewed with pharcotic pain med 10. (Resident #13) Findings include		F0329	F 329 I. Resident #13 was provided narcotic pain medic as per order. The licensed s member who failed to correct sign out and document the administration of the medica has been addressed. II. In a effort to identify any other concerns regarding incorrect signing/ documentation of narcotics, narcotic count she have been reviewed/compar the PRN flowsheets in an effidentify further concerns with thorough documentation. As	etaff titly tion in teles eets eed to fort to

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155232	A. BUI		-	09/27/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8					
					ST NORTH H ST		
I WIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed on 9/20	6/11 at 11:00 a.m.			residents could be affected,	the	
					following corrective actions h		
	Pagidant #13's o	urrant diagnosas includad			been taken: III. As a means		
	Resident #13's current diagnoses included,				ensure ongoing compliance	with	
	but were not limited to, type 2 diabetes				ensuring narcotic pain		
	mellitus and morbid obesity				medications are correctly sig		
					and documented as having b		
	Resident #13 had	d a healthcare plan, dated			administered, directed in-ser training will be provided	vice	
		idicated the resident had a			specifically addressing the co	orrect	
		s, the resident has the			signing out and documentation		
	1 -				administering narcotic	011 01	
	potential for pain related to history of				medications on the PRN		
	fracture and morbid obesity.				flowsheet as per order. Follo	owing	
	Interventions for this problem included,				said in-service training,	_	
	administer pain medication as ordered,				administrative nursing staff w		
	and monitor pair	n medication for			assigned to audit the narcoti	С	
	effectiveness.				records and compare to the		
	circuiveness.				resident specific documentat	ion	
	D :1 . //12.1				(i.e., PRN flowsheet) on		
		d a current physician's			scheduled days of work to er ongoing compliance with the		
	order for hydroc	odone 10-325 (a narcotic			correct signing and documer		
	pain medication)), 1 tablet orally every 4			of narcotic medication	itilig	
	hours PRN (as r	needed) for pain. The			administration. Should		
	· ·	his order was 5/4/11.			noncompliance be noted,		
					re-education and disciplinary	,	
	During abanerati	ion on 0/26/11 at 0:40			action shall be implemented,	if	
	_	ion on 9/26/11 at 9:40			warranted. IV. As a means		
		ninistered hydrocodone			quality assurance, the assigr		
	10 - 325 1 tablet	to Resident #13.			nurse consultant/designee sl		
					conduct, at least, weekly visi		
	During an interv	iew with LPN #1 on			and review the narcotic reco	ras	
	_	.m., she indicated any			and corresponding PRN flowsheets to ensure complia	ance	
	time a resident re				with correct signing and	ai iC C	
					documenting of narcotic		
		ursing staff were			medication upon administrati	ion.	
		ument the medication on			Results of the aforementione		
	the "PRN Medic	ation Flow Sheet." and			audits and immediate correc		
	sign the medicat	ion out on the "Controlled			actions taken shall be reporte	ed to	
	1 -	LPN #1 signed the			the quality assurance commi	ttee	

Facility ID:

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155232	A. BUI	LDING	00	COMPL: 09/27/20	
		100202	B. WIN			09/27/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TWIN CI	TY HEALTH CARE			1	ST NORTH H ST TY, IN46933		
		TATEL IEUT OF DEFICIENCIES			11, 114+0000		(115)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		n the "Controlled Drug			on a quarterly basis for revie	w	
		n documented she			and recommended revision	of	
	administered the medication on the flow				monitoring, if warranted.		
		on the "PRN Medication			Completion Date: 10/11/11		
	· ·	the last entry on the flow					
	sheet.	J					
	A copy of the Ser	ptember 2011 "PRN					
	Medication Flow	-					
	"Controlled Drug	g Record" for Resident					
	#13 were request	ted on 9/26/11 at 12:45					
	p.m.						
	A copy of the "Pl	RN Medication Flow					
	Sheet" and the "O	Controlled Drug Record"					
	were provided by	the RN consultant on					
	9/26/11 at 1:00 p	.m.					
	· •	011, "PRN Medication					
		"Controlled Drug					
		dent #13 were reviewed					
		0 p.m. The "Controlled					
	"	d the PRN hydrocodone					
	ı	d out by nursing staff on					
		o.m., 9/6/11 at 4:00 p.m.					
		:00 a.m. The "PRN					
		Sheet" did not have any					
	l *	cated Resident #13 had					
		eeded hydrocodone pain					
	medication.						
	During on interni	iew with the Director of					
	~	11 at 9:00 a.m. she					
	~	sing staff were to					
	muicaicu ille ilui	sing starr were to					

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION DO TO THE CONSTRUCTION DO TO THE CONSTRUCTION DO THE CONSTRUCTION	ON	(X3) DATE S COMPL 09/27/20	ETED
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	administered on the Flow Sheet" and She further indicated the only place in the nurses document. She indicated the sign out sheets for match. She indicated the explanation as to document they have hydrocodone means the sheet. This federal tag was the facility failed.	why the nurses did not ad given the PRN dication on the flow was cited on 8/12/11.					
F0428 SS=D		of each resident must be once a month by a licensed				•	
	to the attending ph nursing, and these upon. Based on record facility failed to e	ust report any irregularities pysician, and the director of reports must be acted review and interview, the ensure the pharmacy yed the PRN narcotic records for 1 of 3	F0428	provid as per memb	I. Resident #13 was led narcotic pain medic rorder. The licensed s ler who failed to correc ut and document the	taff	10/11/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I4K712

Facility ID:

000137

If continuation sheet

Page 27 of 35

NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE (X4) ID SUMMARY SINTEMENT OF DEPICIENCIES GAS CITY, IN46933 SIMMARY SINTEMENT OF DEPICIENCIES GAS CITY, IN46933 (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) Tag in medications in a sample of 10. (Resident #13) Findings include: The clinical record for Resident #13 was reviewed on 9/26/11 at 11:00 a.m. Resident #13's current diagnoses included, but were not limited to, type 2 diabetes mellitus and morbid obesity Resident #13 had a healthcare plan, dated 8/25/11 which indicated the resident had a problem listed as, the resident had the potential for pain related to history of fracture and morbid obesity. Intervention for this problem included, administer pain medication as ordered, and monitor pain medication for effectiveness. Resident #13 had a current physician's order for hydrocodone 10-325 (a narcotic pain medication), 1 tablet orally every 4 hours as needed for pain. the original date of this order was 5/4/11.		IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
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pharmacist review for compliance. Following said in-service training, administrative/nursing staff will be assigned to audit the narcotic records and compare to the resident-specific documentation (i.e., PRN flowsheet) to ensure ongoing compliance with the correct signing and documenting of narcotic medication administration. Should			_				WCII	
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Resident #13 had a current physician's order for hydrocodone 10-325 (a narcotic pain medication), 1 tablet orally every 4 hours as needed for pain. the original date of this order was 5/4/11. administrative/nursing staff will be assigned to audit the narcotic records and compare to the resident-specific documentation (i.e., PRN flowsheet) to ensure ongoing compliance with the correct signing and documenting of narcotic medication administration. Should		medication as or	dered, and monitor pain			•		
Resident #13 had a current physician's order for hydrocodone 10-325 (a narcotic pain medication), 1 tablet orally every 4 hours as needed for pain. the original date of this order was 5/4/11. assigned to audit the narcotic records and compare to the resident-specific documentation (i.e., PRN flowsheet) to ensure ongoing compliance with the correct signing and documenting of narcotic medication administration. Should		medication for e	ffectiveness.					
records and compare to the resident-specific documentation pain medication), 1 tablet orally every 4 hours as needed for pain. the original date of this order was 5/4/11. records and compare to the resident-specific documentation (i.e., PRN flowsheet) to ensure ongoing compliance with the correct signing and documenting of narcotic medication administration. Should								
order for hydrocodone 10-325 (a narcotic pain medication), 1 tablet orally every 4 hours as needed for pain. the original date of this order was 5/4/11. The cords and compare to the resident-specific documentation (i.e., PRN flowsheet) to ensure ongoing compliance with the correct signing and documenting of narcotic medication administration. Should		Resident #13 had	d a current physician's			<u> </u>	С	
pain medication), 1 tablet orally every 4 hours as needed for pain. the original date of this order was 5/4/11. (i.e., PRN flowsheet) to ensure ongoing compliance with the correct signing and documenting of narcotic medication administration. Should			• •			•	ion	
hours as needed for pain. the original date of this order was 5/4/11. ongoing compliance with the correct signing and documenting of narcotic medication administration. Should		_	`					
of this order was 5/4/11. correct signing and documenting of narcotic medication administration. Should								
of narcotic medication administration. Should								
		of this order was	3/4/11.			of narcotic medication	-	
I During observation on $0/26/11$ at 0.40								
		_				noncompliance be noted,	_	
a.m. LPN #1 administered hydrocodone corrective action/ disciplinary			•			· · · · · · · · · · · · · · · · · · ·		
re-education shall be conducted as warranted. Additionally, the		10 - 325 1 tablet	to Resident #13.					
DON shall be responsible to							i i C	
During an interview with LPN #1 on monitor the consultant pharmacist		During an interv	iew with LPN #1 on				nacist	
9/26/11 at 9:40 a.m. she indicated any monthly review for evidence of		_						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155232	B. WIN		09/27/20		011
		<u> </u>	B. WIIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	3			ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
				L			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
1710	time a resident re	· · · · · · · · · · · · · · · · · · ·		1110	ongoing monitoring of correc	t	Ditte
					narcotic administration as	`	
		tursing staff were			conducted by the consultant		
		ument the medication on			pharmacist. IV. As a means		
		ation Flow Sheet." and			quality assurance, the assigned		
	1 -	ion out on the "Controlled			nurse consultant/designee sh		
	1	LPN #1 signed the			conduct, at least, weekly visi and review the narcotic record		
		on the "Controlled Drug			ensure compliance with corre		
	Record" and then	n documented she			signing and documenting of		
	administered the	medication on the flow			narcotic medication upon		
	sheet. The entry	on the "PRN Medication			administration, as well as	,	
	Flow Sheet" was	s the last entry on the flow			consultant pharmacist report evidence of continued monitor		
	sheet.	•			of the same. Results of the	Jillig	
					aforementioned audits and		
	A copy of the Se	eptember 2011 "PRN			immediate corrective actions		
	Medication Flow	•			taken shall be reported to the		
		g Record" for Resident			quality assurance committee		
	I .	sted on 9/26/11 at 12:45			quarterly basis for review and potential revision of monitoring		
	_	sted oil 9/20/11 at 12.43			as warranted. Completion D		
	p.m.				10/11/11		
	A C41 !!D	DNIM. H					
	1	RN Medication Flow					
		Controlled Drug Record"					
	1 1	the RN consultant on					
	9/26/11 at 1:00 p	o.m.					
	The September 2011, "PRN Medication Flow Sheet" and "Controlled Drug						
	Record" for Resi	ident #13 were reviewed					
	on 9/26/11 at 2:0	00 p.m. The "Controlled					
	Drug Record" h	ad the PRN hydrocodone					
	medication signe	ed out by nursing staff on					
	_	p.m., and 9/6/11 at 4:00					
		Medication Flow Sheet"					
	_	entry which indicated					
	1	d received the as needed					

000137

	OF CORRECTION	IDENTIFICATION NUMBER: 155232	A. BUI	LDING	00	COMPL 09/27/2	ETED
		100202	B. WIN			03/2//2	V11
NAME OF F	ROVIDER OR SUPPLIE	₹		1	DDRESS, CITY, STATE, ZIP CODE		
TWIN CI	TY HEALTH CARE			1	ST NORTH H ST FY, IN46933		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICI I		DATE
	hydrocodone pai	in medication.					
	During an interv Nursing on 9/26 indicated the nur document any Pi administered on Flow Sheet" and She further indic the only place in nurses document indicated the PR sign out sheets for match. The clinical record Consultant Pharmand reviewed Re- record on 9/14/1 make any notes which would incondifferences betwo Flow Sheet" and Record". This federal tag The facility failed	iew with the Director of /11 at 9:00 a.m. she raing staff were to RN medications they the "PRN Medication asign out the medication. The reacted the flow sheet was the medical record the red PRN medications. She red indicated the Facility macist was in the facility macist was in the facility resident #13's clinical 1. The Pharmacist did not in the clinical record licate he noted the reen the "PRN Medication at the "Controlled Drug" was cited on 8/12/11. The deto implement a correction to prevent					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVIDENTIFICATION NUMBER: A. BUILDING B. WING D9/27/2011		ETED			
	PROVIDER OR SUPPLIER			627 EAS	DDRESS, CITY, STATE, ZIP CODE ST NORTH H ST TY, IN46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0514 SS=D	each resident in accordessional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission scresstate; and progress Based on record facility failed to medications were the clinical recorreviewed with pharcotic pain med 10. (Resident #13 Findings include The clinical recorreviewed on 9/26 Resident #13's cubut were not limit mellitus and more Resident #13 had 8/25/11 which in problem listed as potential for paintfracture and more	review and interview, the ensure narcotic pain e documented correctly in d for 1 of 3 residents hysician's orders for dication in a sample of dication	F0	514	F 514 I. Resident #13 was provided narcotic pain medic as per order. The licensed s member who failed to correct sign out and document the administration of the medicat has been addressed. II. As a residents receiving narcotic medication(s) could be affect the following corrective action have been taken: III. As a m to ensure ongoing compliance with ensuring narcotic pain medications are correctly sig and documented as having be administered, directed in-sentraining will be provided specifically addressing the consigning out and documentation administering narcotic medications as per order. Following said in-service train administrative/nursing staff wassigned to audit the narcotic records on scheduled days of work and compare to the resident-specific documentation (PRN flowsheet) to ensure ongoing compliance with the	taff tly ion all red, ns eans ee ned een vice orrect on of ning, vill be c f	10/11/2011

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
ANDILAN	OF CORRECTION	155232		LDING	00	09/27/2	
		100202	B. WIN		DDDEGG CITY OTHER TIN CODE	00/21/2	011
NAME OF	PROVIDER OR SUPPLIER	8		1	ADDRESS, CITY, STATE, ZIP CODE ST NORTH H ST		
TWIN CI	TY HEALTH CARE			1	TY, IN46933		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG		4:	DATE
	1 ^	medication as ordered,			correct signing and documer of narcotic medication	iting	
	and monitor pair	medication for			administration. Should		
	effectiveness.				noncompliance be noted,		
					re-education and/or disciplina	-	
		d a current physician's			action shall be implemented, warranted. IV. As a means		
	1	odone 10-325 (a narcotic			quality assurance, the assign		
	1 *	, 1 tablet orally every 4			nurse consultant/designee sl	nall	
	1	needed) for pain. The			conduct, at least, weekly visi		
	original date of t	his order was 5/4/11.			and review the narcotic record ensure compliance with the	rds to	
					correct signing and documer		
	During observation on 9/26/11 at 9:40				of narcotic medication upon	9	
		ninistered hydrocodone			administration. Results of the		
	10 - 325 1 tablet	to Resident #13.			aforementioned audits and		
					immediate corrective actions taken shall be reported to the		
	_	iew with LPN #1 on					
		.m. she indicated any			on a d ng, if		
	time a resident re						
		ursing staff were			warranted. Completion Date 10/11/11	::	
		ument the medication on			10/11/11		
	the "PRN Medic	ation Flow Sheet." and					
	1 -	ion out on the "Controlled					
	Drug Record"	LPN #1 signed the					
		on the "Controlled Drug					
		n documented she					
	administered the	medication on the flow					
	sheet. The entry	on the "PRN Medication					
	Flow Sheet" was	the last entry on the flow					
	sheet.						
	A copy of the Se	ptember 2011 "PRN					
	Medication Flow	Sheet" and the					
	"Controlled Drug	g Record" for Resident					
	#13 was request	ed on 9/26/11 at 12:45					
	p.m.						

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S	ETED	
		155232	B. WIN			09/27/2	011
NAME OF F	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE		
TWIN CI	TY HEALTH CARE			1	ST NORTH H ST TY, IN46933		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Sheet" and the "O was provided by 9/26/11 at 1:00 p. The September 2 Flow Sheet" and Record" for Resion 9/26/11 at 2:00 Drug Record" has	RN Medication Flow Controlled Drug Record" the RN consultant on o.m. 2011, "PRN Medication "Controlled Drug ident #13 were reviewed to p.m. The "Controlled and the PRN hydrocodone ed out by nursing staff on					
	9/5/11 at 11:00 j and 9/22/11 at 13 Medication Flow	p.m., 9/6/11 at 4:00 p.m. 1:00 a.m. The "PRN v Sheet" did not have any cated Resident #13 had					
		eeded hydrocodone pain					
	Sheet" for Resid provided by the entries of PRN n the 9/26/11 entry the observation of	"PRN Medication Flow ent #13 which was RN consultant had 4 nedications listed below made by LPN #1 during on 9/26/11 at 9:40 a.m licated Resident #13 had					
		/12/11 at 3:00 p.m., a.m., 9/19/11 at 1:15					
	Nursing on 9/26	iew with the Director of //11 at 3:10 p.m. nation was requested					

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155232	B. WIN			09/27/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ST NORTH H ST		
T\A/INI CI	TV UEALTH CADE						
I WIIN CI	TY HEALTH CARE			GAS CI	TY, IN46933		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	related to the dif	ferences in the "PRN					
	Medication Flow	v Sheet".					
	During an interv	iew with the Assistant					
	_						
		ing on 9/26/11 at 3:40					
	1 ^	ed she had made the					
		RN Medication Flow					
	Sheet" after the	records were requested					
	and facility had	noted the differences.					
	She indicated sh	e had spoken to the					
		_					
	nurses working on the dates noted above and they indicated they had given the						
	1	to Resident #13. She					
		ould have made the					
	entries a "late en	tries" and she did not do					
	so.						
	During an interv	iew with the Director of					
	_	/11 at 9:00 a.m. she					
	_						
		rsing staff were to					
	1	RN medications they					
		the "PRN Medication					
	Flow Sheet" and	sign out the medication.					
	She further indic	cated the flow sheet was					
	the only place in	the medical record the					
	nurses documented PRN medications. She indicated the PRN flow sheet and the						
		or the medications should					
	match.						
	This federal tag	was cited on 8/12/11.					
	The facility faile	ed to implement a					
	1	correction to prevent					
	recurrence.	F10.000					
	1 TOCUITORICC.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **|4K712**

Facility ID: 000137

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 7/2011
	PROVIDER OR SUPPLIEI		627 EA	ADDRESS, CITY, STATE, ZIP C ST NORTH H ST ITY, IN46933	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	3.1-50(a)(1) 3.1-50(a)(2)					